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PROJECT, INC.

TESTIMONY OF KATHLEEN FLAHERTY, ESQ.
EXECUTIVE DIRECTOR, CT LEGAL RIGHTS PROJECT, INC.
PUBLIC SAFETY AND SECURITY COMMITTEE PUBLIC HEARING
MARCH 10, 2020

In opposition to: SB 428, AN ACT CONCERNING ASSISTED OUTPATIENT TREATMENT FOR CERTAIN PERSONS WITH PSYCHIATRIC DISABILITIES.

Senator Bradley, Representative Verrengia, Senator Hwang, Representative Sredzinski and distinguished members of the Public Safety and Security Committee:

Good afternoon. My name is Kathy Flaherty and I'm the Executive Director of Connecticut Legal Rights Project (CLRP), a statewide non-profit agency that provides legal services to low income adults with serious mental health conditions. CLRP was established in 1990 pursuant to a Consent Order which mandated that the state provide funding for CLRP to protect the civil rights of DMHAS clients who are hospitalized, as well as those clients who are living in the community. I'm also the Co-Chair of the Keep the Promise Coalition (KTP). KTP is a coalition of advocates (people living with mental health conditions, family members, mental health professionals and interested community members) with a vision of a state in which people with mental health conditions are able to live successfully in the community because they have access to housing and other community-based supports and services that are recovery oriented, person-driven and holistic in their approach to wellness. Lastly, I'm a member of the steering committee of the Connecticut Cross Disability Lifespan Alliance, an alliance of people of all ages with all disabilities who pursue a unified agenda.

A review of the history of involuntary outpatient commitment proposals is in order.

SB 428 represents the latest iteration of a proposal to institute IOC in Connecticut. Public Act 96-215 established a task force to study involuntary outpatient commitment in Connecticut. Their report was issued in January 1997 and can be found here: http://www.narpa.org/reference/task.force.report Notably, the task force did not recommend either adoption or dismissal of the concept of involuntary commitment. They noted that "[t]he question remains, "Is there a case for some form of involuntary outpatient commitment for a very narrow target population considered to represent a risk of violence in the community?""

In 2000, two bills were introduced, HB 5699 and HB 5783. The Judiciary Committee held public hearings on both bills, referred the bills to Appropriations, where they died. In 2012, SB 452 was raised by the Judiciary Committee for a public hearing; that bill never made it out of committee. In 2013, the Young Adult Behavioral Task Force issued their report and could only encourage "further study" of IOC. The Sandy Hook Advisory Commission (on which I served) stated in its final report, issued in 2015, that it was "unable to arrive at a recommendation concerning adopting IOC as an option short of involuntary hospitalization in Connecticut." In 2016, HB 5331 had a hearing in the Judiciary Committee, and never made it out of committee.

Three times the legislature requested research reports from the Office of Legislative Research: in 2001 (2001-R-0866), 2011 (2011-R-0438), and 2013 (2013-R-0105) on what other states do with regard to involuntary outpatient commitment. A lot of time and effort has been expended on examining IOC, only to have the legislature reject it each time it is proposed. **I urge you to reject SB 428, and hope that this bill represents the last time a proposal to institute involuntary outpatient commitment is put forward for consideration by the legislature.**

Expansion of involuntary medication to the community is a step backward.

It has long been recognized that all people have a constitutional right to bodily integrity, which includes the right to refuse medical treatment including psychiatric medications. "An individual has a constitutionally protected liberty interest in avoiding involuntary administration of antipsychotic drugs. . ." Sell v. United States, 539 U.S. 166, 178-79 (1992). When forced medication is used "to alter the will and

the mind of the subject, it constitutes a deprivation of liberty in the most literal fundamental sense." Washington v. Harper, 494 U.S. 210, 237-38 (1990).

Presently, the law allows for involuntary medication in a psychiatric hospital under certain limited circumstances and with strict due process protections. It mandates procedures that protect patients' rights, including notice to the patient of available advocacy services, notice of any proceeding not less than forty-eight hours in advance, notice of the right to representation and the right to question witnesses.

Expansion of involuntary medication into the community is not only a limitation of constitutional rights, it is unnecessary. Connecticut is in the forefront of mental health treatment. Our recovery-oriented system of community treatment is a model for other states. We have options available that include peer support, advance directives and Housing First. Forced medication in a community setting would be counter to the patient-centered approach that is the hallmark of most current social service programs in our state. Forced medication as set out in this proposed statute would, therefore, be very expensive. Especially in these dire days of fiscal emergency, our resources would be much better spent increasing access to supportive housing and other community treatment and support options.

No Magic Pills

It is important to note that while psychotropic medications help some people, there are others for whom they are not helpful. The diagnosis and treatment of psychiatric conditions is not an exact science. It may take trial and error over time to discover an effective regimen. As with any medical condition, sometimes something that was once working stops working. Some people are accused of not taking their medication when in fact, it's a matter of their medication simply not working. Sometimes people develop adverse effects that require changes in medications. Psychotropic medications are powerful and can cause severe and irreversible side effects. It is therefore not unreasonable for an individual to refuse to take medication in accordance with a doctor's clinical recommendation. Failure to comply is not a psychiatric symptom or evidence of a psychiatric disorder. Trusting and respectful relationships encourage sharing of these concerns and discussions of options. Forcing treatment encourages avoidance of treatment providers.

Discrimination

This bill singles out people with psychiatric disabilities for loss of self-determination with no proven benefits to them or to the public. I understand that there are some people whose conditions are difficult to treat and whose situations frustrate and worry their family members, treatment providers and judges. However, sacrificing the rights of many people to deal with a few complex situations, using an ineffective methodology, is wrong.

International Law from the United Nations has found that forced psychiatric treatment may amount to torture.

I am someone who has been subjected to forced psychiatric treatment, including forced hospitalization, seclusion, restraint, and forcible medication. That intervention occurred nearly 30 years ago. The trauma that resulted from that intervention still remains. It is not merely psychiatric survivors who say that forced treatment is harmful: The U.N. Special Rapporteur on Torture recently submitted a report on torture and other cruel, inhuman or degrading treatment of punishment. In paragraph 37 of the report, the following was noted (emphasis added)

> 37. **It must be stressed that purportedly benevolent purposes cannot, per se, vindicate coercive or discriminatory measures.** For example, practices such as involuntary … psychiatric intervention based on "medical necessity" of the "best interests" of the patient (A/HRC/22/53, para.20, 32-35; A/63/175, para.49), … generally involve highly discriminatory and coercive attempts at controlling or "correcting" the victim's personality, behaviour or choices and almost always inflict severe pain or suffering. In the view of the Special Rapporteur, therefore, if all other defining elements are given, such practices **may well amount to torture**. (Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment of punishment - A/HRC/43/49, available at: https://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session43/Documents/A_HRC_43_49_AUV.docx)

Conclusion: The Public Safety and Security Committee should reject this bill.

SB 428 is premised on the purported link between mental illness and violence, even though that link is more a matter of perception than actual truth: the major risk factors for violence are demographic and economic, not diagnosis: those who are young, male, and of lower socio-economic status are more likely to commit acts of violence. Those living with mental health conditions are more likely to be victims of violence. Second, predictions of violence by psychiatrists are not that accurate – experts have been forced to admit that their predictions are really no better than chance. Third, this bill operates on the assumption that medications work to address symptoms – another mistaken assumption.

It is unconscionable that in a time when people cannot access community-based services because they are not available as a result of funding cuts, that there would be a proposal to set up a system in which treatment is forced on someone who doesn't want it, and depends on monitoring and supervision by under-resourced and over-stretched agencies simply to watch an individual subject to an order of involuntary outpatient commitment take their medication. This bill requires the court to find that the respondent "will voluntarily take medication for the treatment of his or her psychiatric disabilities." [lines 58-59]

This bill does not center the people who need access to services and supports. Frankly, their experience seems to be an afterthought. The last thing on the list of what comprises what the bill calls "assisted outpatient treatment" is the "attempt to develop a rapport with the participants and earn their trust." [lines 18-19] I can guarantee you, as a former patient, that the likelihood of establishing rapport and earning trust when treatment is coerced is next to nil.

This bill would have a huge fiscal note. This state cannot afford it. Unless and until people have a legally enforceable right to the community-based services and supports they need, and until the state adequately funds the community non-profits that provide the services and supports, this state has no business instituting involuntary outpatient commitment. Please reject this bill.